INTERIM STUDY

BY THE

SUBCOMMITTEE ON FINANCE AND CLAIMS

INSTITUTIONS

December 1974

Montana Legislative Council
State Capitol
Helena, Montana 59601

Membership
Subcommittee on Finance and Claims

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C. An educational program should be undertaken by the Department of Social and Rehabilitation Services (SRS) to help people in Montana communities understand the need for community living for the developmentally disabled.

D. State aid and supplements for foster and group homes should be increased to facilitate movement of BRSH residents to the community.

E. SRS should provide in-service training programs, as needed, for all social workers and community workers on characteristics of the developmentally disabled and on methods of developing community services.

F. BRSH should be used for evaluation, intensive care, and training until communities are able to accept all BRSH residents.

II. Warm Springs State Hospital (WSSH)

A. The admission and discharge procedures for WSSH should be restructured to insure that:

1. all persons admitted to WSSH have had a proper evaluation in the community; and

2. all persons discharged from WSSH have access to proper post-institutional care in the community.

B. WSSH and the regional mental health centers and clinics must develop closer ties to strengthen admission and discharge procedures to WSSH.

III. General Recommendations

A. Institutions

1. The state institutions should have a staff-to-patient ratio conforming to professional standards for

staffing.

2. Institutional employees should be compensated at a higher rate, commensurate with their responsibilities and the state's need to attract a stable labor force.

B. Community Programs

1. All community programs should maximize services and minimize administrative and financial duplication.

2. Local governments should participate in the funding of community programs.

3. Wherever possible, community programs should be locally controlled.

4. The legislature should consider potential federal funds available when funding community programs.

HOUSE RESOLUTION 89

A RESOLUTION OF THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING THE COMMITTEE ON PRIORITIES TO ASSIGN TO THE APPROPRIATE STANDING COMMITTEE A STUDY OF THE PROBLEMS RELATING TO STATE INSTITUTIONS AND THEIR EMPLOYEES AND HAVE IT REPORT ITS FINDINGS TO THE FIRST REGULAR SESSION OF THE FORTY-FOURTH LEGISLATURE.

WHEREAS, the problem of employing and retaining employees in state institutions has been and continues to be of paramount significance to the legislature, and

WHEREAS, the salaries of most of these employees have been and continue to be at or near the poverty level according to federal standards, and

WHEREAS, institutional employment is unique for a number of reasons a few of which are:

(1) Employees are required to provide care to the mentally ill, retarded and socially problematical;

(2) Employees are required to travel much farther from their residences to their employment than most other state employees because of the isolation of institutions;

(3) Adequate housing is not available on or adjacent to state land;

(4) Physical working environment is less than desirable in many instances, and

WHEREAS, the proper care and treatment of residents of state institutions requires dedicated staff with highly developed skills beyond those which have been recognized by any legislature to date.

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Committee on Priorities is requested to assign to the appropriate standing committee a study of the problems relating to state institutions and their employees.

BE IT FURTHER RESOLVED, that this study be done in conjunction with the Department of Institutions.

BE IT FURTHER RESOLVED, that the standing committee report its findings and recommendations, along with any proposed legislation, to the first regular session of the Forty-fourth Legislature.

INTRODUCTION

The Committee on Priorities assigned House Resolution No. 89, "A Study of the Problems Relating to State Institutions and Their Employees", as an interim study for the subcommittee on Finance and Claims.

The resolution lists six problem areas for employees: turnover rates, salaries, travel, housing, physical working environments, and problems related to care of the mentally ill, the mentally retarded, and the "socially problematical". At its first meeting, the subcommittee decided not to discuss employee classification and compensation until the Personnel Division of the Department of Administration had audited and classified the jobs at the institutions and had recommended compensation for institutional employees as part of the Wage and Classification Plan. For this reason, the subcommittee directed its main interest toward gathering information relative to how best to provide the care to the people committed to state care. To fully understand the scope of the problem the subcommittee visited Galen State Hospital, Warm Springs State Hospital, and Boulder River School and Hospital. The subcommittee also met with Boulder and Warm Springs employees to learn of their concerns.

In addition to studying problems of the institutions, the subcommittee investigated community alternatives to institutionalization. The subcommittee studied material prepared by the staff and visited the programs in their own towns. Particular attention was given to programs for the mentally ill, the mentally retarded, and juveniles.

This report discusses the subcommittee's view on institutions and community alternatives. While no specific legislation is proposed, the subcommittee hopes that the legislature will use the following recommendations as a guide for establishing priorities for budgeting.

BOULDER RIVER SCHOOL AND HOSPITAL (BRSH)

The subcommittee recommends that community-based services that relate to BRSH be expanded as a means of reducing the present population and preventing future admissions to the institution.

Use of community-based services will provide residents released from BRSH with a less restrictive form of treatment than that provided in an institutional environment and will reduce the need for extensive addition of staff and physical plant at BRSH.

Montana has established limited community services for the developmentally disabled (DD),[1] including group homes, foster homes, sheltered workshops, day care, activity centers, recreation programs, and transportation services. Expansion of these services will allow greater flexibility in solving the problems at BRSH.

BRSH residents returned to the community should be placed according to their needs and abilities and the capabilities of the communities, with state assistance, to provide necessary services.

Not all residents of BRSH require the same services. To more fully understand the services needed, the subcommittee reviewed a report prepared by the BRSH social services staff. (Table 1). That report estimates the types of residential services that would be required if all present BRSH residents were returned to the community.

Thirty-five residents, for example, need skilled nursing care -- twenty-four hour per day attention. Another seven residents could live independently or semiindependently with occasional supervision, if community placements were available. There are 126 persons who need foster care. They are primarily younger children who would do best with parental orientation. A large number of adults and adolescents -- 270 -- are in a group home category and another 69 persons could be placed in either a group or foster home. Finally, 18 residents require intensive treatment to correct maladaptive behavior.

In addition to residential services, communities must also have support services such as programs in education, employment, recreation, and transportation. Just as the normal population find these services necessary for community life, so too will DD persons. These services are the key to whether a DD person can remain in the community or will be placed into BRSH.

While communities must be able to provide these services, they should also be willing to do so. The subcommittee urges SRS to conduct educational programs in the communities to increase the awareness of the need for community life for DD persons. BRSH residents were not born in the institution--they came from the communities.

To reverse this trend will be to ask all non-DD individuals in the community to no longer use the expedient alternative of institutionalization for those persons they find different from themselves. Instead, available community programs and services must be recognized. This recognition can only occur when the services are in fact available and the community has been made aware of their availability.

It should not be forgotten that the total number of residents at BRSH is only a small minority of all DD persons in the state. The majority of DD persons are already in the community. These

TABLE 1

Boulder River School and Hospital
Projected Living Arrangements
Summary
September 19, 1974

AREA	I/SI*	SNC	FH	GH	FH/GH	TC	TOTAL
Region I	1	5	20	41	15	1	83
Region II	0	8	18	49	11	0	86
Region III	2	8	37	62	13	5	127
Region IV	2	6	17	49	8	4	86
Region V	0	2	15	27	6	1	51
Sub-Totals	5	29	107	228	53	11	433
Out-of-State	2	5	15	39	14	6	81
Unknown	0	1	4	3	2	1	11
Totals	7	35	126	270	69	18	525

*I/SI -- Independent/Semi-Independent Living
SNC -- Skilled Nursing Care
FH -- Foster Home
GH -- Group Home
FH/GH -- Foster or Group Home
TC -- Treatment Center (Maladaptive Behavior)
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NOTE: All data are based on most current address of parent, foster parent, or guardian; not on recorded county of financial responsibility.

Also, 156 of the above individuals are physically handicapped and will require special facilities to accommodate wheelchairs and/or other adaptive equipment.

persons, like those returning from BRSH, will need to move closer to the mainstream of services if they are to remain in the community.

To facilitate movement of BRSH residents to the community, the subcommittee recommends that the state aid and supplement for foster care and group homes be increased.

As noted previously, the BRSH Social Services staff estimates that for purposes of community placement, 126 residents need foster care, 270 require group home care, and another 69 should be placed in either a foster or group home setting. Some operators of group homes and foster care parents indicated that the present state payment was not sufficient for the cost of care of persons in these situations. After reviewing the present state payments for foster care and group homes, information comparing these payments to those paid by other private and public agencies, is presented below.

The Department of Social and Rehabilitation Services currently has 950 children in foster care. Eighty of these children are handicapped either physically or mentally or both. For care of a handicapped child, the department currently pays foster parents a maximum of $125 per month (compared to $90 or $100, depending on age, for normal children). The state and counties share equally the cost of children's foster care. The amount of state payment is limited by budget, not statute.

There are 169 adults in foster care in Montana -- 106 are disabled and 63 are aged. Adult foster care is done either in homes where there are three or less persons in such care or in group homes (two to eight persons) licensed by SRS as adult foster care facilities.

State payments for adult foster care are made as a state supplement to Supplementary Security Income (SSI) -- the federal public assistance program. The state supplement (effective July 1, 1974) is $49 per month; added to the federal SSI payment of $146 making a total of $195 per month. Group homes usually charge residents $175 per month for board and room. This leaves the resident $20 per month for personal expenses.

Table 2 compares rates paid for foster care by three public and one private agency in Montana. The rates paid by SRS for foster care for BRSH residents it places are the lowest of the four agencies.

The amount of care required for the four types of children -- multiple handicapped, emotionally disturbed, juveniles in need of supervision or delinquent, and handicapped -- is not totally comparable. The Developmental Disabilities Bureau which is the highest paying agency, probably asks foster parents to provide the greatest amount of personal care.

TABLE 2

Payments for Foster Care of Children by Three Public and One Private Agency in Montana (November, 1974)

PLACING AGENCY	TYPE OF CHILDREN	AGES	PAYMENT TO PARENTS	MEDICAL/ DENTAL	CLOTHING	OTHER	TOTAL
DD Bureau[1]	Multiple Handicapped	0-8	$260 (average)	Covered	All reasonable costs covered.		$260 (average)
Casey Family Program[2]	Emotionally Disturbed	8-15	$210 (under 12) $237 (over 12)	Covered	All tutoring and special needs covered.		$210-$237
Institutions[3]	Juveniles in need of supervision or delinquent	12-21	$150	Covered	$15/month (as needed)	$10 allowance $10 incidental	$170
SRS	Handicapped	0-18	$90-125	Covered	Basic wardrobe provided (if needed)	Allowance for special costs- $25 (max.)/mo.	$90-125 plus $25 (max.)/mo.

[1] The Developmental Disabilities Bureau of SRS has a $54,000 grant for intensive foster care for 14 children. Costs are set primarily by foster parents. Five children have been placed and costs range from $200 to $325 per month.

[2] The Casey Family Program uses funds from its foundation to provide private long-term foster care.

[3] The Department of Institutions, Bureau of Aftercare, has 53 youths in foster placements in nine District Youth Guidance Homes and one Aftercare Home.

The Bureau will place a total of 14 children from BRSH. Therefore, when comparing rates it should be noted that SRS would be called upon to place these children if the DD Bureau did not make the placements. SRS, however, would attempt placement for the maximum payment of $125 per month compared to the average $260 per month that the DD Bureau has found necessary to pay.

The amount of payment by the DD Bureau, SRS, and institutions is determined by budget limitations. The DD Bureau, however, pays according to reasonable costs incurred by the foster parents. The Casey Family payment is split between board and room costs and a service fee of $100 per month. The service fee is paid to encourage foster parents to continue in instances where problems with the child might make them want to quit the program. The fee is also in recognition that the parents have skills and are providing a service.

Table 3 compares foster care payments for handicapped children in seven western states. With the exception of North Dakota, where no exact figures are available, Montana pays near the bottom of the scale. Generally, these states set payments according to the age of the child and budget limitations, although Utah and Colorado pay according to the needs of the child and the ability of the parents to provide requisite skills to meet those needs.

In November 1974, SRS completed a cost study for care of normal children. Foster parents kept a record of cost for 15 categories during a period of one month. Costs for handicapped children should generally be higher. The results from 24 homes with normal children are as follows:

Ages	Cost/Month
0-6	$124.67
7-12	$142.99
13-18	$192.35

The subcommittee also examined group home costs. Table 4 lists resident cost per day and per month for five different group living arrangements. DD group homes had the lowest cost of operation, but the costs only ranged from $11.08 (adjusted DD group home rate per day) to $13.39 (District Youth Guidance Homes rate per day).

Some differences should be noted. In the two largest facilities -- the alcoholic treatment centers and the Denny Driscoll Boys Home -- the former often have large mortgage or rent payments, while the latter has no such cost because its home was donated. Further, the average length of stay is probably longer in DD homes than the other facilities.

State support for the homes also varies. For example, a

TABLE 3

Payments for Foster Care of Handicapped
Children in Seven Western States (November, 1974)

STATE	AGES	BASIC PAYMENT	MEDICAL/ DENTAL	CLOTHING	OTHER	TOTAL
Utah	under 11 over 11	$161-236 214-296	Covered	$50 initial	Allowances for special costs such as lessons, equipment, therapy, transportation, etc.	$161-296 plus $ 50 clothing
South Dakota	0-6 7-11 12-14 15-18	$175 175 200 200	Covered	$ 8 15 15 20	$ 2 10 10 15	$185 200 225 235
Colorado	0-1 1-6 6-12 12-21	$146-196 158-208 195-245 211-266	Covered	$50 initial	------	$146-266 plus $50 clothing
Idaho	0-18	$150 (average) (negotiable)	Covered	$325 initial (cumulative maximum of $25/month)	Allowances for special costs	$150 (average)
Wyoming	under 10 over 10	$125 145	Covered	Basic wardrobe provided	------	$125-145
Montana	0-18	$90-125	Covered	Basic wardrobe provided	Allowance for special costs-$25 (max.)/month	$90-125 plus $25(max.)/month
North Dakota	0-18	No set scale. Negotiable between counties and parents. High payment would be $200 per month	Covered	------	------	

TABLE 4

RESIDENT COST PER DAY AND PER MONTH FOR GROUP LIVING
(November 1974)

Name	Number of Homes	Number in Homes	Resident Cost Per Day	Resident Cost Per Month
District Youth Guidance	9	10 (max.)	13.39[1]	401.70
Alcoholic Treatment	7	3-40	12.66	379.80
Denny Driscoll Boys Home	1	26-30	12.61	378.30
Aftercare Home	1	8	11.30	339.00
DD Group Homes	6	5-8	9.83[2] [11.08] [adjusted]	294.90 [332.40] [adjusted]

[1] District Youth Guidance Homes resident cost is "Start-Up" cost. The Department of Institutions estimates a $12 per resident day cost when operational.

[2] Two of the DD group homes had unusual budgeting situations, such as no rent or mortgate payments and unusual funds, which made the cost of operation much lower than the other four homes. The adjusted figure reflects the cost of operation for those four homes.

District Youth Guidance Home (through the Department of Institutions) receives $24,375 per year as a grant from the state. In addition, the home receives foster payments from various governmental agencies. An estimated average payment is $125 per month per resident. If the home has an average daily population of seven youths, it can collect $10,500 per year in foster payments. It will therefore have $34,875 per year from the state grant and foster care payments to meet the cost of operation of the home. Based on $13.39 per resident per day cost, the home will cost $33,742.80 per year for seven youth. The home, without local donations, will have $1,132 above its cost of operation.

A DD group home may be the recipient of grants from the Developmental Disabilities Services and Facilities and Construction Act and/or the Hospital Improvement Project. Five homes received these funds in fiscal years 1974 and 1975. Totals for two years of these grants ranged from $5,711 to $20,867; an average yearly grant was $5,246. Funds from Title VI of the Social Security Act also were used in the homes. These funds ranged from $1,800 to $10,800 for fiscal years 1974 and 1975; an average yearly amount of $3,710. Finally, a home usually charges a resident $175 per month for board and room. If the home has an average daily population of six, SSI will bring another $12,600 per year. The total for grants, Title VI, and SSI is $21,556 per year. The cost of operation of the home for six residents for one year is $23,933, based on a per resident per day cost of $11.08. The home is short about $2,400 per year. It must obtain this amount from local donations.

To encourage the growth of foster and group homes, SRS believes that the foster payment for handicapped children should be raised to $195 per month and that group homes should be supplemented at a rate of $250 per resident per month (see Appendix A).

To further strengthen community programs, the subcommittee recommends that SRS provide in-service training programs, as needed, for all social workers and community workers who work with DD persons. The training should include characteristics of DD persons as well as methods of developing community services.

The subcommittee investigation disclosed that county social workers lacked academic training and/or experience with the characteristics of DD and knowledge of how to establish community programs. Universities usually do not require course work in the areas of mental retardation for social welfare majors. Further, most DD persons have not been in the mainstream of community life and therefore social workers, like the general populace, have little experience in working with them.

Without trained personnel in the communities, local programs will face an uncertain future. The possibility of a successful foster placement, for example, is enhanced when the social worker can counsel the parents on what to expect from their child. If

the social worker is intimidated by a DD child or is willing but lacks experience in working with DD persons, he cannot help but shake the confidence of foster parents.

Because of the subcommittees concern over this problem, SRS has contacted all undergraduate schools of social work in the state and asked that areas concerning mental retardation be part of course work for candidates in social work. The University of Montana, Montana State University, Carroll College and Eastern Montana College (which presently provides this information in their undergraduate and graduate school of rehabilitation) assured SRS that they will begin or continue (in Eastern's case) such courses. The University of Montana will offer Social Work 473, "Social Work Practice in Special Settings: Mental Retardation" during winter quarter this year.

Further, SRS negotiated a contract with the University of Oregon Rehabilitation Research and Training Center on Mental Retardation and the University of Wisconsin to provide basic principles and knowledge of the mentally retarded to all SRS staff. This training is scheduled for December 9 and 10 in Great Falls and December 12 and 13 in Billings.

Finally, SRS will provide in-service training program for state personnel and the development of specific skills for all social workers by contract with the University of Montana Continuing Education Program. This training is set for next spring.

The subcommittee expects training programs will continue as needed.

Finally, the subcommittee recommends that BRSH be used for evaluation, intensive care, and training until such time as the communities are able to accept all BRSH residents.

The development of community alternatives will take time. It is not possible to immediately reverse years of using institutionalization as a method of treating DD persons. With proper staffing, salaries, and physical plant, BRSH can provide the preparatory training necessary for its residents' reintroduction to community life.

WARM SPRINGS STATE HOSPITAL (WSSH)

WSSH community programs do not have as great a potential in the near future for reducing that institution's population as do the community programs for BRSH. For example, a patient cannot leave WSSH unless he is able to live by himself or with friends or relatives. No psychiatric halfway houses exist in Montana at

present. Sheltered employment is not as available for former WSSH patients as it is for DD persons. Nor are transportation services purchased for persons released from WSSH as is sometimes the case for DD persons.

Furthermore, social workers and community workers are not developing these services for former WSSH patients and no local workers are assigned the single responsibility of assisting each released patient in securing and using services that do exist.

When a patient is released, the WSSH social services staff refers the individual to a number of services. These may include mental health centers and clinics, family, friends, clergy, county welfare, vocational rehabilitation, nursing homes, local public health, school counselors, private mental and medical professionals, veterans administration, courts and probation officials, social security officials, private treatment centers, and available community programs such as crisis centers.

While referral to one or more of these services may enable the patient to remain in the community, no one person in the community checks to see if the services are utilized. The collective responsibility dims individual agency responsibility. Moreover, WSSH social services staff are not in the community; they are limited to phone calls or letters to determine if the former patient is adjusting satisfactorily.

The readmission rate to WSSH in the last years indicate that either not enough services are available or are not being used in such a manner as to keep many former patients in the community. Following are the first admissions and readmissions for WSSH since 1968:

Year	First Admissions	Readmissions
1968	856	534
1969	973	604
1970	1144	713
1971	1080	675
1972	1032	671
1973	1047	771
1974 (Aug. 31)	561	450

One likely way to reduce both admissions and readmissions is greater utilization of the state's five mental health regional centers and clinics. With few exceptions, WSSH refers its patients to the centers and clinics.

Only within the last few months has Montana completed the establishment of the five centers. When Great Falls and Butte became centers, instead of clinics, they joined Miles City,

Billings, and Missoula as the nuclei of Montana's community mental health programs.

The legal description of the mental health regions is contained in Sections 80-2401 to 80-2411, R.C.M. 1947. A clinic provides outpatient care only whereas a center must provide five services:

(a) twenty-four hour inpatient care;
(b) part-time hospitalization;
(c) outpatient service;
(d) emergency service;
(e) consultation and education in mental health.

While most WSSH patients are referred to the centers and clinics, it appears that many patients do not use the services of the centers and clinics in the months following their release. And if a patient does not come in of his own accord, the centers and clinics (until recently and in only a few cases) have no staff who can meet the person in his home.

Table 5 lists the number of WSSH discharges and mental health centers and clinics follow-ups for the period January 1 to August 31, 1974. WSSH supplied the information in columns 3, 4, and 5; the Bureau of Mental Health provided the figures for columns 6 and 7.

Overall the table indicates that the centers and clinics (as measured by the number of persons who told the centers and clinics that they were referred by a public mental hospital and by the number of persons who said that they had had previous public psychiatric hospital service against the number of discharges made by WSSH into the region) are not seeing most of the patients who are released from WSSH.

For example, WSSH discharged 212 persons into Region V, which has Missoula as its center. Of these 212 persons, 137 were voluntary and 47 were involuntary commitments to WSSH. (Twenty-eight other persons were emergency commitments to WSSH; the majority of these later became voluntary commitments). Little can be done to make voluntary commitments obtain post-institutional care in the community, but every effort should be made to see if they are adequately readjusting.

During the eight month period that WSSH discharged the 212 persons into the region, the Missoula mental health region recorded that 33 people they treated said they were referred from a public mental hospital. Eighty-six persons (including the 33 mentioned before) said at some time in their lives they had had previous public psychiatric hospital service. Therefore, if only 33 persons said they had been referred by a public mental hospital and 86 said they had previous public psychiatric hospital service, then probably more than half of the 212 persons discharged into the Missoula region by WSSH were not seen by the mental health

TABLE 5

WARM SPRINGS DISCHARGES AND MENTAL HEALTH CENTER FOLLOW-UP
(January 1 - August 31, 1974)

Region	Center	Discharges into Region by WSSH	Discharges into Regions Which Were: Voluntary Commitments to WSSH	Discharges into Regions Which Were: Involuntary Commitments to WSSH	Referrals to Centers and Clinics from Mental Hospital	Previous Public Psychiatric Hospital Service
I	Miles City	105	81	16	4	9
II	Great Falls	164	111	45	4	24
III	Billings	156	64	38	34	140
IV	Butte	428	299	49	40	118
V	Missoula	212	137	47	33	86
		1,065	*	*	115	377

*NOTE: An additional 178 persons were admitted on an emergency basis to WSSH. The majority of these admissions later became voluntary commitments.

centers and clinics.

The pattern in the Missoula region appears in the other four regions. Billings, which has the largest staff and facility, appears to be the most effective in seeing persons as they return from WSSH. In terms of the number of patients who have had previous public psychiatric hospital treatment compared to the total number of patients seen, Missoula has the best record with 16%, followed by Great Falls with 11%, and Billings with 9%.

Tables 6 through 9 reveal further information on the treatment provided at mental health centers and clinics. Table 6 lists the major referral sources to the centers and clinics. Table 7 is the kind of services provided to patients at the time they terminated the services of the centers and clinics. Table 8 lists why the patients terminated services without referral and Table 9 shows the types of previous mental services for patients seen at the centers and clinics.

The subcommittee also believes the centers and clinics should play a stronger role in the admissions to WSSH. Presently, referrals from the centers and clinics are a small part of the total admissions to WSSH. This is a matter of concern in that there have been admissions to WSSH which were improper -- the result of inadequate evaluation in the community.

Tables 10 and 11 relate the number of admissions to WSSH and referrals by the centers and clinics. From January 1 to August 31, 1974, 1,011 patients were admitted to WSSH. The mental health regions records indicate they referred 23 persons to a public mental hospital. Very few of the WSSH admissions then are referred by the centers and clinics. To reduce the number of inappropriate admissions to WSSH may require that all recommendations for admission, whether by private or public mental health professionals, be certified by the centers and clinics.

To improve the quality of admissions and the care provided after discharge from WSSH, the subcommittee believes that the centers and clinics must strengthen their relationship with WSSH. A closer coordination must be achieved as soon as possible.

GENERAL RECOMMENDATIONS

Institutions

One of the consistent problems of the state's institutions is attracting and retaining staff. Staff shortages result in overworking existing staff and in some cases using patients to perform necessary work.

TABLE 6

Major Referral Sources to Mental Health Centers and Clinics (January 1-August 31, 1974)

Source	Number
Self	1136
Family	420
School (K-12)	330
Private Physician	320
County Welfare	191
Friend	185
Other	156
Vocational Rehabilitation	132
Mental Hospital	116
General Hospital	76
Court (Juvenile)	64
Other Mental Health Professional	56
Public Health	54
Private Psychiatrist	49
Court (Adult)	48

TABLE 7

Services Rendered at Termination for Patients
Seen at Mental Health Centers and Clinics
(January 1-August 31, 1974)

Service	Number
Outpatient	1,406
Individual Therapy	918
Family Therapy	346
Evaluations for Other Agencies (Psychological Testing, etc.)	155
Intake Only	131
Collateral Therapy	129
Group Therapy	76
Diagnostic Service Without Treatment	64
Chemotherapy	63
Inpatient	53
Day Care	45
Home Visit	34
Post Institutional Care	8
Electrical Stimulation	6
Educational Therapy	5
Recreation Program	4
Night Care	1
Half-way House	1
Day Training	1
Special Education	1

TABLE 8

Reasons for Terminating Service Without Referral by Patients seen at Mental Health Centers and Clinics (January 1-August 31, 1974)

Reason	Number
Dropped Out or Rejected Treatment	662
Further Care Not Indicated at This Time	433
Moved	85
Died	9
Service not Available	8
Community Resource Needed But Not Available	7
Community Resource Available Family-(Guardian) Nonaccepting	5

TABLE 9

Types of Previous Mental Services for Patients
Seen at Mental Health Centers and Clinics
(January 1-August 31, 1974)

Service	Number
None	2007
This Center Only	521
Public Psychiatric Hospital	377
Private Mental Health Professional	325
This Clinic Only	205
Unknown	179
Other Mental Health Clinic	136
Other Mental Health Center	121
Other Pyschiatric Hospitals	101
Partial Hospitilization	13

TABLE 10

REGIONAL ADMISSIONS TO WARM SPRINGS STATE HOSPITAL
AND REFERRALS TO PUBLIC MENTAL HOSPITAL BY
MENTAL HEALTH CENTERS AND CLINICS
(January 1 - August 31, 1974)

Region	Center	Regional Admission to WSSH	Center and Clinic Referrals to Public Mental Hospital
I	Miles City	110	1
II	Great Falls	155	1
III	Billings	145	10
IV	Butte	413	7
V	Missoula	188	4
		1,011	23

TABLE 11

Referral on Discontinuation for Patients
Seen at Mental Health Centers and Clinics
(January 1- August 31, 1974)

Referral	Number
None	1200
School	77
Other	67
Welfare Agency	44
Vocational Rehabilitation	37
Private Physician	35
Legal Service	28
Public Mental Hospital	23
Private Mental Health Professional	18
Justice System	15
Residential Child Treatment Center	10
Clergy	8
Local Health Department	6
Private Mental Hospital	5
Employment Service	3
Other Psychiatric In-Patient Facility	6
Boarding Home	5
Mental Retardation School	1

The subcommittee recommends that the state institutions should have a staff/patient ratio in accordance with professional standards for staffing. The generally accepted standards are those of the Joint Commission on Accreditation of Hospitals, Medicaid/ Medicare, and relevant court cases. To attract and retain the required staff, the subcommittee recommends that institutional employees be compensated at a higher rate than at present; commensurate with their abilities and the need for the state to attract a stable labor force.

Community Programs

The subcommittee recommends that all existing and future community programs, that receive state support, should maximize services and minimize administrative and financial duplication.

The state has an active part in numerous community programs such as those for juvenile delinquency, alcoholism, mental illness, mental retardation, aging, and drug abuse. Several state departments are responsible for these programs and different bureaus under these departments control selected parts of the programs. Generally, community programs operate independently of one another. There are some serious drawbacks to this independence. First, users of the services often do not get all that they should. In some instances, a person may need the services provided in two or more programs. Yet, because programs are so separated, local workers not only do not know each other personally, but also are not familiar with each other's programs to make the proper referral. If referrals are made between programs, the user of the service may be so confused by the different persons and buildings that he simply is unable to avail himself of the services.

Second, because the services are fragmented, the state has not developed a consistent and equitable method of funding community programs. Some programs are funded adequately, while others are underfunded. Further, the state supports duplication in office space, machinery and supplies, and administration in the various communities. For example, separate buildings for two programs require that the state purchase two duplicators when one would serve the needs of both programs. The state can ill afford to have its limited financial resources spent in areas which are not as directly service-oriented as possible.

Third, separate community programs compete for local support. As community programs expand this competition may result in unhealthy conditions. In developing community programs, it is necessary to develop programs that fit the needs of the client. The mentally ill generally do not require services on as an extended basis as do the mentally retarded, for example. While these differences must be noted, it is also true that the development of community programs for all groups have

similarities. It is necessary to determine what residential and support services are necessary and how they may be funded. At this point, competition for support may dilute the overall effectiveness of the programs. The state may want to evaluate its current programs and find those which deliver the greatest service most efficiently, so that all programs may maximize their services.

Local governments face one group, then another, and still others seeking support for their programs. In some cases, local governments are required by state law to participate in the programs (at different levels for different programs, i.e., the mental health centers and Developmental Disabilities Act of 1974 require different local support) and in other instances, no participation is required. Before more community programs are added or expanded, the state should define its role and that of local governments and as well private donors on the local level, to insure that programs are funded equitably and efficiently.

The subcommittee does believe that local governments should participate in the funding of community programs. Fifteen counties at present are nonparticipating counties in the regional mental health system. Successful community programs will require participation by all levels of government.

The subcommittee recommends further that, wherever possible, community programs should be controlled locally by nonprofit groups. State regulations should set standards for performance. Local control will give a more sustained interest in the programs as well as provide assurance that local needs are met.

In calculating the resources to be used for funding community programs, the subcommittee recommends that the legislature consider potential federal funds available. The fact that federal and private revenue expenditures in fiscal 1974 at SRS were 40% above the amounts appropriated by the legislature indicates that as increased federal funds become available they are, in fact, utilized by executive budget amendment. Therefore, unless potential federal funds are considered by the legislature, it is quite possible that the community programs may become substantially larger than legislative intent, and obligate the state to programs the legislature did not envision. While federal funds are useful and necessary for the development of many programs, the subcommittee believes that over reliance on such support may result in a disruption of services or extraordinary supplementation by the state if federal support is significantly reduced in the future. (See Appendix B for an inventory of federal funds available for DD community programs.)

FOOTNOTES

[1] The Developmental Disabilities Services and Facilities Construction Act of 1970 (P.L. 91-517) defines developmental disability as "a disability attributable to mental retardation, cerebal palsy, epilepsy or other neurological condition of an individual found by the Secretary (of Health, Education, and Welfare) to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals which disability originates before such individual attains age eighteen, which has continued or can be expected to continue, indefinitely, and which constitutes a substantial handicap to such individual."

The Big Sky Country

STATE OF MONTANA
SOCIAL AND REHABILITATION SERVICES
Helena, Montana 59601

THOMAS L. JUDGE
Governor

THEODORE CARKULIS
Director

November 20, 1974

Mr. Mike Morris
Legislative Council
Room 138--State Capitol
Helena, MT 59601

RE: S.S.I. Supplement

Dear Mr. Morris:

The following estimates are based upon payments of $195 for both children and adults in foster care and for payments of $250 per person in group care. The estimates are based on a two-year period.

The social services staff at Boulder River School and Hospital has submitted projected living arrangements for 527 residents. According to Janice Frisch, Chief of Social Services, 300 individuals will be placed within the next two years. Two hundred twenty individuals would be appropriately placed in group homes over a two-year period.

There are about 80 individuals who are appropriate for foster care placement, including adults and children, over a two-year period.

We are currently applying for S.S.I. for 78 children now in foster care. Assuming they qualify for a payment of $146 monthly, the supplement over a two-year period amounts to $91,728.

There is an estimate of 80 now in group care. This amounts to an additional expense over a two-year period. This estimate of 80 may be low.

The total amount has been computed on a gradual number of placements over the biennium rather than computing the total amount for a two-year period.

The total amount involved in the supplementation is $635,700.

If you need additional information, please contact me.

Sincerely,

Norma Cutone

Norma Cutone, Chief
Social Services Bureau

NC/ds

APPENDIX B

INVENTORY OF FEDERAL FUNDS AVAILABLE FOR
DD COMMUNITY PROGRAMS[1]

Program	Funds Available FY-1974	Funds Utilized FY-1974	Match Required	Unused
Title IV, Aid to Dependent Children	Open	$ 12,432,685	36.79% State & Co.	Open
Title IV, AFDC Foster Care	Open	N/A (included in) (ADC)	36.79% State & Co.	Open
Child Welfare Services	$ 200,000	$ 237,000	N/A	-0-
Social Services	$8.5 million	$ 4,585,272	3:1	$ 3.5 mil. (approx.)
Title XVI (SSI)	Open	(new program)	Fed. $146 per mo. per client State $49 per mo. per client for foster or group home residents	(new program)
Title XVIII (Medicare)	Open	N/A (federally administered)	6.70/mo. to bring eligible persons into the program	Open
Title XIX (Medicaid)	Open	$ 20,664,825	36.79% state	Open
Title I, ESEA (Retarded Allocation)	$ 324,626	$ 324,626	None	-0-

[1]Prepared by Fiscal Office of Legislative Auditors for Subcommittee on Finance and Claims.

Program	Funds Available FY-1974	Funds Utilized FY-1974	Match Required	Unused
Vocational Education	$ 204,000	$ 204,000	50/50	-0-
Special Education Part B Title VI, (ESEA)	$ 200,000	$ 200,000	-0-	-0-
Maternal and Child Health Services	$ 1,291,500	$ 610,800		
Rehabilitation Services and Facilities - Basic Support	Open	$ 2,345,000	80:20	Open
Voc. Rehab. Services for Social Security Disability Beneficiaries	Open	SSI $ 104,507 Trust Fund - $ 214,146	None	Open
Developmental Disabilities Basic Support	$ 103,353	$ 103,353	90:10 24 months 80:20 life 72:25 Planning & Administration	Open
Developmental Disabilities Special Projects	N/A	-0-	Grant	Open
(Hill Burton) Health Facilities Construction Grant	$ 1,276,318	$ 1,276,318	State matches up to 40%	-0-
Rehabilitation Services and Facilities - Special Projects	$ 37,586	$ 37,586	Grant	-0-
Foster Grandparents Program	N/A		None	N/A


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